



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

**MEDICAL EQUIPMENT REQUEST EVALUATION FORM
NON-WHEELCHAIR**

This evaluation must be completed by a New Hampshire **licensed** physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator must have an understanding of the recipient's condition for which the equipment is being requested and broad knowledge of the various rehabilitation equipment available in the market today that may benefit the recipient. **NOTE:** Requests for wheelchair equipment should not be made on this form. Wheelchair equipment requests should be made using, "Form 272M - Mobility Evaluation."

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ **RECIPIENT MEDICAID ID #:** _____
RECIPIENT HEIGHT: _____ **RECIPIENT WEIGHT:** _____

PROVIDER INFORMATION (FOR LICENSED MD/OT/PT PERFORMING THE EVALUATION)

PROVIDER NAME: _____ **NH MEDICAID PROVIDER #:** _____
ADDRESS: _____ **CITY/STATE/ZIP:** _____
TELEPHONE #: _____ **FAX #:** _____
DATE OF EVALUATION: ____/____/____ **PLACE OF EVALUATION:** _____
DIAGNOSIS (written, not ICD-9) PRIMARY: _____
SECONDARY: _____

EQUIPMENT REQUESTED:

Stander Gait Trainer Positioning Chair Bath Equipment Other (non-wheelchair only) _____

Please provide medical justification for providing the equipment requested above:

Is the requested equipment replacing a piece of equipment that the recipient currently has? Yes No

Does the requested equipment duplicate a piece of equipment that the recipient currently has? Yes No

If **YES** to either of the above, please answer the following:

Model and make of current equipment: _____

Age and condition of current equipment: _____

Reason for replacing or duplicating: _____

Where is the primary location of use? Home School Other _____

Given the recipient's age and expected rate of growth, what is the anticipated number of years the recommended equipment is expected to be functional? _____

With respect to the growth potential of the recommended equipment, what is the maximum height and weight capacity?

Height: _____ Weight: _____

How frequently is the equipment expected to be utilized each day or week, and for how long each day or week?

Has the recipient completed a trial period of at least two (2) weeks with the recommended equipment? Yes No

Is similar equipment currently available or being utilized by the recipient at school, home, or other site? Yes No

If **YES**, please explain: _____

Please identify any plans to obtain funding from any other sources (e.g., private insurance, Grants, "Medicaid to School"):

What other, less costly equipment alternatives have been considered (provide specific makes and models)? Why were they not chosen? _____

Please explain why no other alternative equipment options were considered, if applicable: _____

Please check **ALL** that apply regarding the recommended equipment:

- Recipient's home has sufficient space to utilize and store the equipment.
- Potential growth of recipient has been taken into consideration in selecting the size of equipment, which should provide at least 5 years of use.
- Recipient or recipient's caregiver has demonstrated proficiency in the safe operation of the equipment.
- Less costly models have been ruled out as inappropriate.

ADDITIONAL COMMENTS:

SIGNATURE OF NH LICENSED OT/PT OR PHYSICIAN COMPLETING THE EVALUATION

DATE

INDIVIDUALS PRESENT DURING EVALUATION:

- 1) _____ Representing/Relationship to recipient: _____
- 2) _____ Representing/Relationship to recipient: _____
- 3) _____ Representing/Relationship to recipient: _____

RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

I accept the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

I do not agree with all of the recommendations and I request changes based on the following:

SIGNATURE OF RECIPIENT/PARENT/LEGAL GUARDIAN

RELATIONSHIP

DATE

MEDICAL EQUIPMENT SUPPLIER

Please check the statement that applies. If a statement does not apply, please provide your response in the comments section below:

I concur with the recommendations made, and I am unaware of any other **less costly** equipment models or alternatives in the market at this time that would meet this recipient's needs.

To the best of my knowledge, the recipient **does** **does not** expect to receive a similar piece of equipment from any other funding source.

COMMENTS: _____

SIGNATURE OF AUTHORIZED MEDICAL EQUIPMENT
SUPPLIER

DATE

PRINTED NAME OF AUTHORIZED REPRESENTATIVE

PRINTED NAME OF MEDICAL EQUIPMENT COMPANY

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

*Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.*

53 Regional Drive ■ Suite 201 ■ Concord, NH 03301 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335